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# Implementation Date Nears for HHS Emergency Preparedness (EP) Rule

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On November 16, 2017, many U.S. health care entities will be expected to fully comply with new federal emergency preparedness requirements. *Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers* (the "EP Rule"), issued by the Centers for Medicare & Medicaid Services (CMS), became effective November 16, 2016.

In the 2013 proposed rule, CMS said it had concluded that "the current regulatory patchwork of federal, state, and local laws and guidelines, combined with the various accrediting organization emergency preparedness standards, falls far short of what is needed to require that health care providers and suppliers be adequately prepared for a disaster." Where federal requirements apply, they may be outmoded, lack sufficient depth, or be inconsistent across facility types.

The EP rule applies to 17 health care provider and supplier types, shown in **Table 1**, as a condition of their participation (CoP) in the Medicare and/or Medicaid programs. Each participating provider or supplier will be required to comply with requirements in four core emergency management elements: (1) emergency planning, (2) policies and procedures, (3) communications planning, and (4) training and testing. CMS estimated that the first year of implementation for all participating providers would require more than 3 million burden hours, at a cost of almost $280 million.

Under the EP rule, all participating providers must develop risk-based emergency plans. (Simply put, providers in hurricane-prone areas have different preparedness priorities than those in "tornado alley," and their respective plans should reflect this.) They also must develop and maintain policies and procedures to address a range of specific concerns. For example, inpatient providers' plans, policies, and procedures must address subsistence needs, evacuation plans, and shelter-in-place (SIP) plans. (In **Figure 1**, a hospital uses a generator to meet patient safety needs while sheltering in place after tornado damage.) Home health agencies and hospices must inform local officials of patients who need evacuation during an emergency. Long term care (LTC) facilities and psychiatric residential treatment facilities must share information from the provider's emergency plan with residents and family members or their representatives.

**Figure 1. Mobile Generator and Portable AC Unit, Morgan County Appalachian Regional Healthcare, West Liberty, Kentucky**

**Source:** HHS, "Kentucky Healthcare Coalitions from Response to Recovery," https://www.phe.gov/Preparedness/planning/hpp/events/Pages/kytornado-2012.aspx. (Close dialog box to access.)

**Notes:** In March 2012, tornadoes in eastern Kentucky severely damaged Morgan County Appalachian Regional Healthcare, the critical access hospital in the area. Mobile generators, previously procured by the state with federal assistance, were brought in from other health care preparedness regions in the state.

Participating providers must have communications plans that address specified matters. For example, hospitals, Critical Access Hospitals (CAHs), and LTC facilities must be able to track and communicate occupancy rates in real time in order to assist emergency responders with evacuation planning and mass casualty management. Participating providers of all types must have redundant means to contact staff and treating physicians, and must conduct trainings and drills to assure they can execute their emergency plans.

The EP Rule may apply to most providers of a given type, only a portion, or none at all. Most hospitals participate in the Medicare and/or Medicaid programs and must be compliant. Many outpatient facilities do not participate and would not be subject to the rule. The EP rule generally would not apply to residential care communities—known by various names including "assisted living" or "group homes"—which provide housing and services (e.g., room and board, personal care, and transportation, among others) to individuals with long-term care needs. Nonparticipating providers, although not subject to federal CoPs, may be subject to state and local emergency preparedness requirements.

The EP Rule emphasizes facility- and provider-specific emergency planning and training. For some provider types (e.g., hospitals), the rule may not impose a steep learning curve. For others, particularly outpatient facilities, compliance may be more challenging.

The EP Rule expands upon CMS's expectations of inpatient facilities when they are unable to maintain a safe environment for their residents as a result of a disaster. For example, current requirements for LTC facilities require them to maintain "[c]omfortable and safe temperature levels, to have emergency plans, and to have emergency power for lighting, fire safety, and life support equipment." The EP Rule specifically requires LTC facilities to additionally address "[a]lternate sources of energy to maintain ... [t]emperatures to protect resident health and safety," plans to shelter residents in place, and plans to evacuate them safely should the day come when best-laid plans are insufficient.

**Table 1. Provider and Supplier Types Subject to the EP Rule**

| Provider or Supplier Type | Statutory Citation | Regulatory Citation (42 C.F.R.) |
|---|---|---|
| **Inpatient Providers** | | |
| Hospitals | SSA §1861(e)(9) | 482.1–482.66 |
| Critical Access Hospitals (CAHs) | SSA §§1820, 1861(mm) | 485.601–485.647 |
| Long Term Care (LTC) Facilities | | 42 CFR 483.1–483.180 |
| • Skilled Nursing Facilities (SNFs) | SSA §1819 | |
| • Nursing Facilities (NFs) | SSA §1919 | |
| Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Residential Treatment Facilities (PRTFs) | SSA §§1905(a), 1905(h) | 441.150–441.182 483.350–483.376 |
| Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID): | SSA §1905(d) | 483.400–483.480 |
| Religious Nonmedical Health Care Institutions (RNHCIs) | SSA §1821 | 403.700–403.756 |
| Transplant Centers | SSA §§1861(e)(9), 1881(b)(1) | 482.68–482.104 |
| **Outpatient Providers** | | |
| Hospices | SSA §1861(dd)(1) | 418.52–418.116 |
| Ambulatory Surgical Centers (ASCs) | SSA §1832(a)(2)(F)(i) | 416.2 and 416.40–416.52 |
| Programs of All-Inclusive Care for the Elderly (PACE): | SSA §§1894, 1905(a), 1934 | 460.2–460.210 |
| Home Health Agencies (HHAs) | SSA §§1861(o), 1891 | 484.1–484.55 |
| Comprehensive Outpatient Rehabilitation Facilities (CORFs) | SSA §1861(cc)(2) | 485.50–485.74 |
| Community Mental Health Centers (CMHCs) | SSA §1861(ff)(3)(B)(i)(ii) PHSA §1913(c)(1) | 410.110 |
| Organ Procurement Organizations (OPOs) | SSA §1138, PHSA §371 | 486.301–486.348 |
| Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services | SSA §1861(p) | 485.701–485.729 |
| Rural Health Clinics (RHCs) | SSA §1861(aa) | 491.1–491.11 |
| Federally Qualified Health Centers (FQHCs) | SSA §1861(aa) | 491.1–491.11, except 491.3–494.180 |
| End-Stage Renal Disease (ESRD) Facilities | SSA §§1881(b), 1881(c), 1881(f)(7) | 494.1–494.180 |

**Source:** EP Rule, 81 *Federal Register* 63862.

**Notes:** SSA = Social Security Act; PHSA = Public Health Service Act.

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